1406

Rosenthal contribute to your decision to make the 75 percent/25 percent allocation?
A. She, along with a variety of people, contributed to that decision.
Q. And in particular you remember that she did contribute to that one?
MR. NALVEN: Objection.
A. She was involved in -- in conversations regarding a variety of data issues, as were a number of -- of my colleagues at Harvard. So, I -- I can't remember whether Albuterol was her primary focus.
Q. I didn't ask whether it was or not. Did she venture an opinion, provide any information that you used in making the 75 percent/25 percent allocation?
A. I asked my staff to look at this data and -- and -- and do the -- gather whatever data it was possible to do within a period of time in which we -- we were allowed to give his most refined a set of estimates for these allocations we could get, and this is what I received.

1407

Q. Right. And did Doctor Rosenthal say anything or venture an opinion that was used by you or your staff in arriving at the 75 percent/25 percent allocation?
MR. NALVEN: Objection.
A. I think I've -- I think I've answered.
Q. No, I think you haven't.
A. She's -- she's part of a group that led to these results.
Q. Did anything she did lead to that result in particular?
A. I don't know.
Q. Okay. That's an answer. Now, you -- are you aware that under the Connecticut Medical Assistance Programs, at least some of them, reimbursement may be at the federal upper limit?
A. I am.
Q. The methodology you described to Mr. Herold would not have allowed you to identify which payments historically had actually been made at the upper -- the federal upper limit rather than on the basis of AWP, is that correct?

1408

MR. NALVEN: Objection.
A. If you let me check one thing. (Witness reviews document.) Since I'm looking at -- in Connecticut I'm looking at Attachment D to that -- to the -- to my expert disclosure of November 1st, 2005, and I'm looking at -- this was submitted as Attachment D to my affirmative declaration in support of class in this matter.
Q. "This matter" the MDL?
A. The MDL.
Q. Well, we're talking Connecticut now. But whatever. Go ahead.
A. You -- it is my understanding that the federal upper limit is required to be set at an amount of 150 percent of a published AWP -- of the lowest AWP or WAC in a standard pricing compendium. And as I've observed for most drugs, 150 percent of the lowest AWP is usually above the estimated acquisition cost in a generic setting where there are three generics.
So, when I read the Connecticut statutes to say that reimbursement is going to be the

1409

lesser of FUL or usual or customary or the estimated acquisition cost, the lowest of those prices are invaluably the estimated acquisition costs.
So, yes, I know that FUL was cited there and if -- if that were used in a particular case, then it was used in -- in contravention to how I read what the enabling Connecticut statutes were for that reimbursement, which I have taken as the basis for reimbursement for Connecticut.
Q. Well, let's -- let's look at some FULs that were actually in place during this period --
A. Okay.
Q. -- for drugs that you actually compute damages for without regard to them.
A. Okay.
MR. NALVEN: Objection.
MR. KAUFMAN: So, this will be the next exhibit. I don't know what that is.
(1999 Redbook marked Exhibit Hartman 063.)
Q. If you turn to the first page of what

1410

I've just handed you, I'm telling you I don't expect you to know that this is an excerpt from the 1999 Redbook that says on the first page after the cover, "The following list provides federal upper limit prices for Medicaid reimbursement of multiple source drugs effective September 1, 1998."

And then underneath in the column to the left, there's Albuterol listed. The first item under it is A-R-D-I-H 90 MCG17GM, and then the FUL listed there is $7.47." Do you see that?

A. I do.

Q. Okay. If you turn to two pages after that -- I'm going to get this right -- let me see. (Witness reviews document.) Yeah. Two pages after that, two items down "Warrick --" it says there, "Warrick, ARDIH .09 MG per INH," and then it gives an NDC number. And it lists the AWP for that NDC --

A. I'm sorry. I'm sorry. I'm trying to see the dosage comparison here.

Q. Yeah, I think that's on the page in

1411

between.

A. They're slightly different units.

Q. I know. This is hard to follow. Sorry. And then on the second -- if you go to the third page of the document -- so, the cover page, the first page --

A. No -- yeah. I see that price.

Q. Okay. There's an Albuterol, HCFA -- okay. That's 747. 90 MCG. The next page gives you the -- the 21 -- $21.41 for the AWP and an NDC.

Now, if we look at -- let's see --

A. (Witness reviews document.) I'm -- can I --

Q. Yes, I haven't finished taking you anywhere yet, because I have to put a lot of things together, but go ahead if you have a question.

MR. NALVEN: Steve, it might be helpful if you held up the document and pointed to the specific entry that you wanted him to look at.

MR. KAUFMAN: Okay.

1412

A. Well, let me just ask, I'm seeing on the first page we're talking about the federal upper limit, Page what's 7 -- Page 79, and under ARDIH, 90 MCG, 17 grams, $7.47.

Q. Which is the upper limit, right?

A. It says that that's the federal upper limit.

Q. Then if you go down a little bit -- yes, okay. Right.

A. Okay. So, let's -- if we're sticking with that, then I'm seeing on the next page where it seems you were going.

Q. Above the gray in the middle column?

A. Right. I'm seeing ARDIH, 90 MCG 17 grams.

Q. 17 grams. The same $7.47 upper limit?

A. Which is here characterizing it as the AWP at the top of the column, which I don't.

Q. No, I don't understand that, because the next one, AWP for that same one is $21.41.

Does it say AWP? (Reviews documents.) Yeah, I think this is -- this is not clear.

1413

A. I think that's fair to say.

Q. I think the AWP is -- you'll remember that Medicare defines reimbursement for multi-source drugs as the AWP, which it defines to be the lesser of FUL or median AWP for all NDCs in the J-Code.

So, AWP on the second page is AWP for reimbursement purposes, which, by definition in Medicare, is FUL or median AWP.

A. Wait. Wait. Wait. Wait. Are we talking about --

MR. NALVEN: Let me --

A. -- Medicare or --

MR. NALVEN: Excuse me. Is there a question pending, or are you asking Doctor Hartman to look at something specifically on the document? 'Cause -- 'cause I'm lost at this point.

MR. KAUFMAN: I know, because we're -- I would like him to see that there is an FUL for an NDC that is included in his calculation of damages for Connecticut.

A. And I will certainly acquiesce to my

1414

understanding that there are FULs for -- for multi-source drugs that meet the criteria under the -- what I had just read in the footnote --
Q. Okay.
A. -- to Attachment D.
Q. Now, this FUL might have been the basis for reimbursement historically, right? $7.47. Whether it was or not depends on whether it was lower than the median AWP for the J-Code in which Albuterol figures for Medicare purposes, right?
MR. NALVEN: Objection.
A. What -- you're mix -- are we talking about med -- you were talking to me about Medicaid and FUL and Medicaid statutes.
Q. Yes, that's right. For Medicaid it would be the lower of FUL or, say, 12 percent off or 8 percent off of AWP, right?
MR. NALVEN: Objection.
Q. For Connecticut Medicaid.
MR. NALVEN: Objection.
A. It would be -- it's -- it's -- it's laid out in Paragraph 13-C under the -- under the

1415

Connecticut statutes. What I state there -- I mean, it's in the report.
Q. Right.
A. "Statutes refer to a variety of pricing bases including but not limited to the federal upper limit." So, yeah, that's something that's a possible price; "Usual and customary amount and amount billed." And then it goes on to describe what it is my understanding has been the billing practices under Medicaid based on relationships between FUL and what acquisition costs were and ASP. And so, that's -- that's stated there, and yes, I know that FUL is a -- is a possibility 'cause I -- I admit to it.
Q. Right. And the FUL for this inhaler -- this is an Albuterol inhaler, NDC 599301560-01 is $7.47 as --
MR. NALVEN: Are you asking him to read the document?
Q. -- as can be determined from looking at Exhibit Hartman 063.
A. So, let me look at Exhibit -- Exhibit

1416

Hartman 063, oh. But I want to look at Exhibit Hartman 055 to see whether that -- you've just given me a J-Code -- I'm sorry -- an NDC and I'm not seeing an NDC here. I'm just seeing it as product description that I want to relate to a J-Code --
Q. Okay.
A. -- or to an NDC.
Q. To an NDC?
A. And so -- and -- (Witness reviews document.) And there's not enough. I think this is a question that would need more foundation for me to track what I'm seeing here in the Connecticut report.
Q. Right. It's not in your report. It's only in the backup material to your report, which I'll give you right now.
MR. KAUFMAN: Let's mark the backup.
(Warrick Medicaid Spreads marked Exhibit Hartman 064.)
Q. Now, do you recognize this?
A. It -- have I seen this particular backup

1417

spreadsheet and did I ask my staff to print this out for me? I looked at various ones. I don't know if I -- if I saw this one for Albuterol.
Q. Okay. I'll tell you that -- so that it's clear on the record, we printed this off the CD --
A. Right.
Q. -- that you provided as the material on which you relied in preparing your reports in Connecticut.
A. Okay.
Q. Okay? Now, where is the NDC? (Reviews documents.) If you look at the first page of -- Exhibit Hartman 064 this is --
A. First page, right.
Q. -- there's an inhaler, Warrick inhaler, 90 MCG ACT. The NDC is 59930156001.
A. ACT. Now --
Q. Do you see that, though? At least do we see that?
A. Well, I see that. I'm trying to confirm that that is the same -- it has the 90 MCG. I

1418

don't know -- I don't know if it's 17 grams. I'm trying to see --
Q. Uh-huh.
A. -- whether I'm seeing these different things with the -- you can have different percentages of micrograms and then grams. So, I'm --
Q. Yeah.
A. I see that. I mean, I'm not -- I can't -- I can't confirm that that's a one for one.
MR. NALVEN: Let him ask the questions. We've been on this line of questioning for 15 or 20 minutes, and I'm not sure we're getting anywhere.
MR. KAUFMAN: We are. Slowly. So, you'll just have to be patient. I'm trying to -- par.
(Counsel confer.)
Q. Okay. Yes. If you look down at the bottom of the second page --
A. Right.
Q. -- to that same NDC number.

1419

A. So, it's the 6001.
Q. 6001, yes.
A. Right. Okay.
Q. If you go over to the columns with years --
A. Right.
Q. -- you'll see 21.41.
A. Yeah.
Q. That's an AWP.
A. Right. It certainly is.
Q. If you go back to Exhibit Hartman 063 to the fourth page where there is the second item down from the top, ARDIH 09 MG/INH, 17 grams, there's that same NDC, and the same AWP, 21.41.
A. I see that. Again, it's -- it's -- the point -- so, it -- it looks like that is the -- the 90 micrograms, and whether it's the MCG and the MG that -- you know, I -- subject to checking that these are the same dosages, that's -- this is .09 milligram -- MG -- per inhaler, and the other version that you're pointing out to me is 90 MCG. But let's just say right now those are the same --

1420

same amounts. You know, I'd have to check that to --
Q. That's fine.
A. But I'm willing to -- I'll -- I'll assume that's the case.
Q. Good. Thank you. If it's the case -- if it's the case, as I think you'll confirm that it is, there is an FUL of $7.47 in 1999 applicable to that. That's what's said on the first page after the cover in Exhibit Hartman 063, FUL $7.47. Do you see that?
A. That's right. I see that.
Q. If you go back to Exhibit Hartman 064 and you look at the ASPs that you compute, which are on the last page of that exhibit, for 1999, you compute an ASP of 1.16. Do you see that?
A. I do.
Q. 7.47 is higher.
A. The -- I'm sorry. 1 --
Q. 1 -- -
MS. NEMIROW: It's 2.10.
Q. Oh. 2.10 I'm looking at the wrong one.

1421

Sorry. 2.10.
A. 1999 you're talking about.
Q. 1999. That's right.
A. Okay.
Q. Now, the actual reimbursement was supposed to have been at the lower of the FUL or the percentage off of AWP --
A. No --
Q. -- for Medicaid, what was actually reimbursed by Connecticut in 1999 for this product was supposed to have been the lower of FUL, which is $7.47 --
A. Right.
Q. -- or 92 percent of AWP. Now, 92 percent of AWP is a lot higher than $7.47. AWP is $21.41, right?
A. The --
Q. So, the amount actually that should actually have been reimbursed was $7.47.
A. No.
Q. Why not?
A. Because if you look at Paragraph 13-C,

1422

my reading of the statutes, and I'm not -- not a lawyer, was that the -- in the -- the various places in which alternative prices are used for what reimbursements take place at is -- it's the lesser of the price for AWP, FUL, usual or customary, amount billed, or the estimated acquisition cost.

Q. That's right. So, let's apply that to Albuterol inhaler -- this Albuterol inhaler in 1999 in Connecticut.

A. Right.

Q. How many of the dollars that were in that lump sum dollar figure you got from the state, how many of those dollars were attributable to a unit of this inhaler, $7.47 probably, not 92 percent of $21.41?

MR. NALVEN: Objection.

A. Well --

Q. Right.

A. Where -- on what do you base that? What -- according to the statute, what should have been reimbursed was $2.10 on the -- on the third page.

1423

Q. That's what you're -- in your but-for world. I'm trying to figure out how much was actually paid.

A. Right.

Q. How much was actually paid by the state --

A. Right.

Q. -- when it paid for this product under its Medical Assistance Program in 1999.

A. Uh-huh.

Q. How much? Well, it should have been the lower of the AWP then in effect, less the discount --

A. Uh-huh.

Q. -- or the FUL, which was $7.47. Since the discount from AWP is higher than $7.47, the amount that should have been paid for this was $7.47, from which you might subtract some other number that you think is the right number, but you're subtracting it from $7.47, not 92 percent of $21.41, right?

MR. NALVEN: Objection.

1424

A. When I -- when I see --

THE WITNESS: Did we not include Table D-1 into this -- into this thing?

MR. NALVEN: You can respond to Mr. Kaufman.

A. The -- the reimbursement formulation as I have assumed for Connecticut is reflected in both the statutes that I've reviewed -- the statutory language and statutes I've reviewed in the complaints; it's been based on my review of the Medicaid reimbursement formulae that I have seen and I have put forward in Attachment D to my declaration on class certification, the attachment of which is appended to the expert disclosure here, but the -- the particular table that is not attached here, and what shows that under Medicaid what the State of Connecticut was reimbursing was AWP -- was precisely what I have in the paragraphs 13 through 15, that they were reimbursing for a -- for a multi-source drug, AWP less 12, from 1995 through 2003, and then AWP less 40 percent starting in 2003. And that's what I find the CMS

1425

stating the reimbursement under Medicaid should be, and I find that, yeah, the statute says it should have been lower than FUL. It should have been lower than that still. That it should have been at ASP, the acquisition cost.

But I find that the statutes that I read that I've been asked to take as given and the CMS description of what the reimbursement rates under Medicaid should be listed on the CMS Web site in 2004 says you're going to reimburse a multi-source drug like Albuterol at AWP less 40 percent. And there is the additional statutory requirement here for certain physician-administered drugs, AWP less 90.25 percent.

So, I've been -- this is what is the -- the price that -- I'm assuming that the price that was used is what appears in -- in the statutes and that I've seen summarized in the Medicaid and that I've seen summarized here, and that it should have been the lesser of a variety of prices, but I've seen nothing in -- and that's what I've been asked to implement in the damage calculation. But I

1426

haven't seen anything that tells me that your description of the world is -- that -- that they've -- that they've overridden the AWP less 40 percent with the FUL in any of the materials I've seen.

Q. Well, for $7.47 is not more than $21.41, is it?

MR. NALVEN: Objection. I'm going to instruct you not to answer. That's just a harassing question.

MR. KAUFMAN: Well, I don't think that.

MR. NALVEN: Please move on.

MR. KAUFMAN: I would like to. Thank you.

Q. $7.47 is the FUL for this product in 1999. The AWP was $21.41, right?

A. And the ASP was $2.10.

Q. Right. And did anyone tell you that Connecticut did not follow the rule you say describes the world as it was in 1999? Namely, that they reimbursed at the lesser of FUL or 12 percent off AWP?

1427

A. Materials that I have reviewed tell me that they relied on AWP less the percentages that I put forward in my -- in my declaration as it appears and as stated. If you have information that they -- otherwise, I didn't see it, and please, by all means, have your expert put it forward.

Q. Well, let me just make sure I understand what you did. I thought you --

A. You under -- we've just gone through what I've done very clearly. You understand what I've done.

Q. Then let me make it clear for the record what you've done, which is to ignore a statutory basis for reimbursement and assume it didn't occur without any basis for that assumption, is that correct?

A. No, that's --

MR. NALVEN: Objection.

A. That -- I'm astounded by that question.

Q. Flabbergasted, maybe flabbergasted?

A. Flabbergasted.

1428

MR. NALVEN: Objection.

A. Flabbergasted. That's a spread that violates several speed limits.

MR. NALVEN: Doctor Hartman, let Mr. Kaufman ask an appropriate question.

Q. Okay. So, your methodology would not have detected payments that were not based on AWP, correct?

A. My methodology has taken the CMS that I have seen and the contractual information that I have seen and the discovery information that I have seen that tells me that they've reimbursed at AWP less a certain percent, depending on the year and the drug.

Q. And your methodology would not have detected payments that were not based on AWP, correct?

MR. NALVEN: Objection.

A. My methodology did not do a claim-by-claim analysis to demonstrate if there was a -- a consistent deviation from the reimbursement formula that -- formulae that I see built into the

1429

-- in the statutes and into the CMS regulations.

Q. And it would not have detected payments that were not based on AWP, correct?

MR. NALVEN: Objection.

A. It didn't -- it didn't look for them.

Q. And didn't -- it wouldn't have detected them if they had occurred --

MR. NALVEN: Objection.

Q. -- correct?

A. The -- this methodology has been developed to reflect the reliance on AWP that is discussed in the -- throughout the MDL filings. Now, if -- if you're saying, does my methodology detect wide variations from that type of reimbursement policy, I've seen no evidence to suggest that that's the case. And my methodology is not designed to look for that. So, I mean, if -- if you're saying is my method that's -- my methodology was not -- was not looking for that.

Q. And wouldn't have found it if it had occurred, right?

A. It didn't look for it.

1430

MR. NALVEN: Objection. Asked and answered.
Q. Well, if you could see things that you weren't looking for, you would not have detected payments that were not based on AWP following your methodology, correct?
MR. NALVEN: Objection. Asked and answered.
A. It -- it -- it didn't look for it.
Q. Okay. We'll stop on that line.
MR. KAUFMAN: Would you mark this, please.
(Revised complaint, 3/5/04 marked Exhibit Hartman 065.)
Q. All right. I've shown you, Doctor Hartman, the revised complaint in the case of State of Connecticut against Dey, Roxane, Warrick, and others. Do you see that?
A. It has been placed in front of me, yes.
Q. You're welcome to look through it to satisfy yourself that it is what I say it is or you can take my word for it, that's up to you.

1431

A. I take your word for it.
Q. If you look at Page 75, you'll see a Table 1-3 that lists the drugs and NDC numbers that are -- of Warrick -- that are challenged in this lawsuit. Do you see that?
A. I do.
Q. All right. Now, was it your understanding that you're opinions in this case should relate to those drugs that are challenged in the case?
A. We're talking about -- my opinions were put forward in -- regarding methodology were put forward in my expert disclosure. Are we talking about the calculations that I was asked to do in -- are you talking about the calculations in January and February?
Q. Well, we'll -- I understood -- let me just go slowly here. I think you told Mr. Herold that you had reviewed the November 1st disclosure before it was made.
A. That's right.
Q. And you believed it accurately

1432

summarized the opinions that you held in this matter.
A. That's right.
Q. And the matter is the Connecticut case, right?
A. It's the Connecticut case. It -- it didn't identify specific drugs at that point.
Q. No, I understand.
A. Okay. Well, you're asking me.
Q. I'm going one step at a time.
A. Okay.
Q. And January 19th, was it your understanding that you were to have addressed in that declaration the drugs that were accused in the cases in Connecticut?
A. It was my understanding I was to put forward a general methodology that could address any drugs, and at the time that actual calculations were requested, that that list of drugs was narrowed for reasons that were not shared with me.
Q. Okay. So that not all of the drugs

1433

originally accused were the subjects of your damage calculations.
A. That's correct.
Q. Were there drugs not accused that were the subjects of your damage calculations?
A. The drugs that were the subject of my damage analysis appear in my damage -- in my damage calculations.
Q. Yes. So, how did you pick them? Why those?
A. Counsel asked me to -- to address those drugs.
Q. Did you understand them to include drugs that were not accused in the Connecticut cases?
MR. NALVEN: The document speaks for itself.
MR. KAUFMAN: Yes, and I'm asking for his understanding of the document.
A. What --
Q. Did you understand your assignment to include the calculation of damages as to drugs for which there had been no complaint?

1434

A. (Witness reviews document.) I understood my assignment as follows: That the initial expert disclosure summarized and reflected the formulaic methodology to -- to conduct the damage analysis, and the damage analysis itself was implemented in January and February for drugs that were identified and singled out to me.

I did not make any type of comparison between drugs that could appear in this document and this. I'd -- I followed the direction of counsel.

Q. So counsel told you which NDCs you should -- for which ones you should compute damages?

A. They told me which drugs to -- to focus on.

Q. Did they tell you to the level of NDC?

A. I don't recall.

Q. Do you know that you included in the Connecticut calculations NDCs that are not accused in the Connecticut complaint?

A. I --

1435

Q. You must have figured I was going to ask you, eh? But go ahead.

MR. NALVEN: Objection. The documents speak for themselves.

MR. KAUFMAN: No. This is him.

Q. Did you know when you computed damages?

MR. NALVEN: No. No. No. The documents speak for themselves.

Q. Did you know --

MR. KAUFMAN: No document tells me that.

Q. Did you know, Doctor Hartman, when you were computing damages in January and in February that you were computing damages for NDCs that had not been accused in the Connecticut complaints?

A. When I laid out the -- the formulaic methodology in my opinions about how damages were to be calculated as summarized in November, they were -- they were generic. They could be -- they could be applied and used for any drug. And it was my assumption at that point -- I mean, I had -- it was my understanding that drugs were in play and NDCs were in play and directions would be

1436

given to me at a certain time when to -- what to focus and how to implement -- what -- what calculations to actually undertake. And at that point I -- I did what -- what was -- what counsel directed me to do.

Q. And so, the answer is that you did know or you didn't?

A. It is something that -- its possibility was implicit, but I didn't spend a lot of time reflecting on that or feeling any need to do anything along the way to take that into account.

Q. Okay. And you didn't take it into account?

A. Take what in, that I might be asked to look at some other drugs?

Q. That you were. Well, let me -- let me direct your attention to Page 5 of 20 of your supplemental declaration in Connecticut.

A. Supplemental. So, we're talking Exhibit Hartman 056.

Q. 5 of 20. This is the February 9th supplemental declaration.

1437

MR. NALVEN: Is it your intention to ask Doctor Hartman to confirm that there are damages calculations for NDCs that are not set forth in Connecticut's revised complaint?

MR. KAUFMAN: You'll hear it in a second.

MR. NALVEN: If you've got a question that can be answered other than by reference to the documents, you can go ahead, but otherwise, you're just wasting time.

Q. Would you turn to Page 5 of 20. Do you see the -- sorry. Are you there?

A. I am.

Q. The Albuterol tabs.

A. Yes, I see the Albuterol tabs.

Q. Now, those are not in the complaint. And I can see that. Everybody will see that. Why did you compute spreads and damages for those NDCs?

A. (Witness reviews document.) The -- so, this is not just in the supplemental. This is in the actual January one, too, right? And I'm

1438

looking at --
Q. Maybe I didn't look in the January one for them.
A. So, they're in both, and as I said when I -- they are in both, and when I -- when I rendered an opinion about how one is to think about this market and to measure damages under the -- the various definitions and thresholds that I've used, I -- I looked at it as being perfectly general. And when I was -- when I was -- the time came to actually -- the data was sufficiently reliable to begin calculating these -- implementing these calculations, these were the -- the drugs I was asked to use.
And they're the same in January and February when I had started -- when -- I saw the -- the revised complaint. Oh, here it is. The fact that the -- that the tabs did not appear there, those are the ones that are of particular interest to you, is that the --
Q. I'm asking -- well, they are of interest because you calculated damages on them, even

1439

though nobody's accused them of everything and they happen to have among the biggest spreads?
A. The -- I've told you what directions I received and -- and --
Q. Was the size of the spread a factor in your including it in your January and February submissions?
A. No.
Q. Did you include every NDC for Albuterol?
A. I would have to -- I would have to -- to check.
Q. Well, what criteria do you remember following in deciding which NDCs to address?
A. I was asked by counsel to address sets of drugs, and I forget what the -- if there were any other criteria. I don't recall. I -- I was asked to do it, and I did it.
Q. Now, when you computed ASPs, did you include, as part of the calculation, the prompt payment discount when it was granted?
A. The -- the dis -- which are we -- what world are we in now? Could you tell me, are we in

1440

physician-administered?
Q. Well --
A. Are we in Connecticut?
Q. I didn't know there was a difference to that question, but if there is, then let's take them one at a time. Let's start with Medicare and the MDL.
A. Okay. For Medicare and the MDL, whatever discounts appeared related to the units that we tracked to the distribution system to the providers that provided the physician-administered Part B drugs were -- were netted out.
Q. So, that's true of any allowance or price concession.
A. That's correct.
Q. Now, do you agree that wholesalers provide services to the manufacturer in the distribution channel?
A. I do.
Q. And isn't their compensation their return on their investment, which is affected by, say, the prompt payment discount?

1441

MR. NALVEN: Objection.
A. The -- how the prompt payment discount would -- which -- who -- who we're talking about as paying promptly? We're talking about the wholesalers paying promptly? What -- which -- I mean, there's various people that can be paying promptly here.
Q. Well, I understand the regular routine in the pharmaceutical industry to be --
A. Right.
Q. -- that if wholesalers pay promptly, then they are given a discount on what they buy from the manufacturer as part of the reimbursement for the services that the wholesalers provide in the distribution channel.
So, let's -- that's who I'm talking about. That prompt payment discount is compensation, among other items, for the services provided by wholesalers?
A. And to the -- I would -- I would want to look at the invoice data that we have to see precisely how that particular financial incentive

1442

was -- was tracked and whether it was included in the charge-back or not, but --
Q. I think it's a discount rather than a charge-back rebate.
A. Yeah, and if it was --
MR. NALVEN: Objection.
A. If it was -- I'd have to look at how it was -- how it was treated, but would the --
Q. And how would that affect your answer -- the question I have pending -- let me just make it clear, because your counsel is justifiably criticizing me for jumping all over. Let me just make sure what the question is. Isn't it -- as an economic matter, isn't it fair for the manufacturers to be compensating the wholesalers for services that the wholesalers provide to the manufacturer in the distribution scheme?
MR. NALVEN: Objection.
A. The -- the distribution, as discussed at length in -- in my affirmative declaration in support of class consists of a -- of a -- of institutional linkages that -- that are known and

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understood, and there are certain discounts paid along the way and certain discounts that ultimately track themselves out into ASPs or are reflected in offsets to prices.
Q. Right. I understand that.
A. Uh-huh.
Q. And aren't some of them attributable to services provided by the wholesalers to the manufacturers that, as an economic matter, warrant compensation?
A. There are -- the wholesalers provide services.
Q. And from what you know of the pharmaceutical industry and its distribution mechanisms, isn't one form of compensation by the manufacturer to the wholesaler for those services the prompt payment discount?
A. A prompt payment discount is -- is offered in this -- in this market and in many markets for prompt payment.
Q. And in the but-for world, you don't give any credit to that element of price concession as

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payment for a service, do you?
A. No, in the but-for world I assume that they're prompt paying the same way that they were before; that that discount is offered, and it's -- and it's paid, and -- but now the -- and it's part of the 30 percent that reduces it to the -- to the targets that we see. So, whatever it was before, it's the same in the but-for world.
Q. I notice that in your calculation of prejudgment interest you use a different interest for -- this is in the MDL particularly, you use a different interest rate for Class 2 than for Class 1?
A. I do.
Q. And why is that?
A. I try and be conservative in both cases, but I take into account the fact that they are different entities with different opportunity costs of capital and that the opportunity cost to consumers or the rate at which the -- the opportunities they might have for their overcharges and their investments is something

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very conservative like a Treasury Bill, treasury note.
Whereas, I assume that a business has returns -- marginal returns that they can invest that is closer to their threshhold investment targets that are represented by costs of capital that are at least at prime rate or higher. So that it reflects the investment opportunities and the value of the funds of those overcharges. So that a dollar lost -- an opportunity loss of a dollar loss to a consumer I'm saying has less of a present value inflation than it might be to a business that could invest it differently than a consumer could.
Q. When were you engaged to start working on the Connecticut case or cases?
A. I don't -- it's my recollection, and I'm -- I think sometime early in 2005, but I can't really recall.
Q. By whom are you engaged?
A. By the law firm of Hagens, Berman, Sobol, Shapiro.

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Q. And what were you engaged to do, your charter?
A. My charter was to develop a formulaic methodology to -- to assess the impacts of the AWP inflation upon reimbursements that were applicable to the state that have been -- and to consumers for -- in the state.
Q. And what investigation did you make in order to discharge that assignment?
MR. NALVEN: Objection. Asked and answered.
Q. I don't know the -- I don't remember the answer, so, please, tell me again. What did you do?
MR. NALVEN: Objection. Asked and answered.
MR. KAUFMAN: I know what he said he was hired to do. I don't know what he said he did. I didn't ask him that.
Q. What did you do?
A. I did that.
Q. How?

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A. I reviewed all the materials that I could review in connection with the MDL matter which involved national types of matters of how markets work nationally, how they work at the state level. It involved valuations of pricing for federal -- a federal agency such as -- such as Medicare and for Medicaid. It involved reimbursement by states. It was the -- the MDL was very broadly focused on -- on issues in this industry, structural and behavioral and performance measures that are standard for economists, both nationally and among states.
Q. Apart from understanding the industry as it worked in Connecticut as well as nationally, what did you do to inform yourself about the reimbursement regimes that were at issue or in play in context during the period?
MR. NALVEN: Objection. Asked and answered.
A. I reviewed as much material as I could about Medicaid, Medicaid reimbursement, Medicaid reimbursement over time, the materials that I had

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received with the complaints for Connecticut, which there were materials that confirmed what I had already been seeing in the MDL matter, because I was seeing state-specific types of -- when I was doing the MDL matter, there were certainly state-related issues that arose and least costly alternative under Lupron, and there are a variety of types of reimbursement issues that involved variation across states. So, I've -- I've been focusing on materials for reimbursement in this market, both nationally and at the state level, for the past three or four years.
Q. What did Connecticut do during this period, from '93 to date, to balance access by its constituencies against price? In other words, what trade-offs did Connecticut consciously make as part of the political process to retain as many pharmacies and physicians and other providers in its system as it could or as it needed to to supply needs to its people while still trying to keep costs down? What did -- what did Connecticut do?

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MR. NALVEN: Objection.
A. I didn't do an analysis of that -- of that question.
Q. What legislative proposals were considered to balance those objectives --
MR. NALVEN: Objection.
Q. -- in Connecticut?
MR. NALVEN: Objection.
A. The --
MR. NALVEN: This is well beyond the scope of his opinions.
MR. KAUFMAN: Well, they inform the reliability of his opinions.
Q. Please, answer.
A. The evolution of --
MR. NALVEN: Objection. Go ahead.
A. -- of the reimbursement formulas and the thinking about reimbursement over time I examined and -- and any related materials that arose in that review I did not take -- and I observed what the implications were in the revealed preferences of -- of what was articulated in the statutes

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regarding reimbursement. I didn't do a -- nor was asked to do a -- any type of involved analysis of a balancing of stakeholder benefits and costs with the evolution of those reimbursement changes over time.

Q. You didn't interpret the reimbursement rates enacted by Connecticut as indicative of Connecticut's expectations as to provider cost, did you?

A. I certainly saw them as reflecting an environment in which there were understandings about provider costs.

Q. What was it about what you saw that gave you that impression?

A. That -- that these are adults that read the newspaper and read magazines and have lobbyists talking to them.

Q. And engage in political processes that have lots of other factors at stake, correct?

MR. NALVEN: Note my continuing objection.

A. What do you -- what do you want me to

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say? Where are we going with this?

Q. I would like you to answer my question.

A. I don't really understand what your question is any longer.

Q. There are a lot of factors affecting the political process other than the participants' estimates of providers' cost, correct?

A. You just asked me a question, there are a lot of other factors affecting the political process besides the manufacturers' costs.

Q. Beside --

A. Yes, my answer to that is yes.

Q. The participants in the political process that led to reimbursement rates in Connecticut, those participants were moved by many things other than their estimate or assessments or expectations about provider costs, correct?

MR. NALVEN: Objection. I mean, if you want to ask him the things that he considered in forming his opinion, that would be an appropriate question, but to ask a blunderbuss question as to whether there are any factors in the world,

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including the temperature or the seismic quakes in Connecticut is not an appropriate question. So, if you'll focus, he'll try to answer.

MR. KAUFMAN: I think he should answer what I've asked.

Q. Will you answer?

MR. NALVEN: Note my objection.

MR. KAUFMAN: Yes. Well, I think everybody knew your objection.

Q. Go ahead.

MR. NALVEN: Objection.

THE WITNESS: Could we have the question read back to the assembly, please.

(Question read back.)

A. Provider costs were one of many things that would affect a -- an ultimate set of decisions regarding reimbursement rates.

Q. Now, did you rely -- in reaching any of the opinions in the November 1st disclosure, the January 19th declaration, or the February 9th supplement, any materials other than those you've provided to the Defendants who requested the

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materials on which you relied?

A. The materials that I relied upon I expect were identified and -- and those I would have, I would have provided. There -- in -- as I begin any endeavor of this sort, I ask my analysis team to gather a much broader set of documents and -- and I review certain things and say, Well, that -- I'm not going to rely on that. It's not sufficiently important here. And so, what I relied on, I assume we've provided.

Q. You don't know of anything that wasn't provided on which you relied?

A. That's correct.

Q. Now, the point you made earlier about your view that Connecticut did not reimburse at FUL, what was the basis for that opinion of yours?

A. Was -- I don't know how many times I have to say it.

Q. Well, forgive me, because I can't keep in mind so much of what you've said. So, please, tell me again.

MR. NALVEN: Objection.

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A. I have reviewed the practices and procedures as they have been implemented in -- into Medicaid and as I've read about them in the CMS, the literature, and -- and how they vary across states and how different states have responded in implementing these -- these reimbursement practices and procedures. I've reviewed the statutes as they applied in the evolution in Connecticut, and those are two of the things that I can recall. There probably were other things.

Q. Did you talk to anybody who was instrumental in operation of the Connecticut Medical Assistance Program?

A. No.

Q. Did you talk to anyone who represented Connecticut in the Medical Assistance Program?

A. My staff did.

Q. To whom did they speak?

A. I would have to -- I'd have to ask them. I --

Q. Well, you might also know. Do you know

1455

to whom they spoke?

A. I would have -- I might know, but if I knew, I'd tell you. I would have to ask them.

Q. Did you rely on anything you were told about what they said?

A. To the extent that there was data and reimbursements levels and other information that was incorporated into the damage calculations, I -- I relied on their ability to -- to talk with the people in Connecticut in finding out about what the -- what their -- what the utilization rates were, and -- and the relevance and appropriateness to the -- to the efforts that I was undertaking.

Q. Now, have you received any academic -- formal academic training in pharmaceutical marketing?

MR. NALVEN: Objection. Asked and answered.

A. No.

Q. Have you any experience in setting prices for pharmaceuticals or designing reimbursement programs?

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MR. NALVEN: Objection. Doctor Hartman's qualifications have been gone through in this deposition at some length.

MR. KAUFMAN: Not in this -- not in Connecticut.

Q. Please go ahead.

MR. NALVEN: Well, in connection with the three-day session that we've been here, including in which your client has been represented.

MR. KAUFMAN: I've been here for these three days, and no one's asked him these questions.

MR. NALVEN: Well, Doctor Hartman's qualifications has been gone through at length.

Q. Okay. So would you answer these questions, please. Do you have any experience setting prices for pharmaceuticals or designing reimbursement programs?

A. I have not assisted in designing reimbursement programs in -- in pharmaceutical markets. I have certainly been involved with

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designing reimbursement or payment systems in other regulated industries, in energy industries, in a variety of regulated industries which take the same types of principles and thinking into account.

In terms of setting prices, I've consulted to industry -- to a variety of different types of manufacturers. I've -- I've consulted to medical device manufacturers and supported litigation work related to medical devices and to pricing of medical devices. And so, I've certainly done that kind of work for medical devices. And I don't see that as being any different than the issues that arise here. As a matter of fact, the issues of pricing reimbursement here are fairly standard to any economist that's trained in industrial organization -- industrial organization and microeconomics. There are very -- very specific types of regulatory issues that may arise, and that's certainly why I pull in colleagues at the Harvard School of Public Health should there be an

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idiosyncratic aspect of this industry that requires specialized knowledge.
Q. Your consulting with medical device manufacturers was before products were launched about the prices at which they would be launched, was it?
MR. NALVEN: Objection.
A. Yeah.
Q. Who? With whom did you consult?
A. I can't reveal that. It's -- well, this is patent litigation subject -- I'd have to find out whether I can -- this is done in patent litigation, and I'm not -- I'm not free to disclose.
Q. It's a litigation context you mentioned earlier that gave me pause, because that's not beforehand. What I'm interested in is whether the consulting you did with that temporally predated the launch and was about the price at which they would launch?
A. It certainly dealt with those issues in an ex-post sense and may have dealt with it in an

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ex-ante sense. I'd have to think back whether the notion of inventing around a patent was -- were some of the issues that were addressed. These are cases that I've done over a period of ten, 15 years.
Q. Were they all patent cases?
MR. NALVEN: Objection.
A. In -- I mean, there could have been a strategic pricing case, but I can't recall right now.
Q. Okay. Have you consulted with the federal or any state government on pharmaceutical reimbursement?
MR. NALVEN: Objection.
A. I have consulted to the FTC regarding drug pricing, and I've consulted to the DOJ regarding reimbursement in -- in regulated industries that were not pharmaceutical but that dealt with similar issues, and to state governments and public utility commissions.
Q. On utility rate setting?
A. That's correct.

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Q. And with the FTC, what was the subject of your consultancy?
A. That was litigation in re: Cardizem.
Q. And the regulated industry or regulated work for the DOJ was outside the pharmaceutical area?
A. From my recollection to date, that's true. I'm currently in conversations with DOJ to -- to enter into consulting about rate setting in the pharmaceutical area.
Q. Rate setting. Well, that's frightening. Okay.
MR. NALVEN: Mr. Kaufman, it's 10 to 5 now. I have a sense that you're wrapping up from the way you're flipping through your outline, is that correct?
MR. KAUFMAN: I'm coming -- five minutes. I think probably five minutes should be enough.
THE WITNESS: Oh, he's got hours left.
Q. Let me just ask one follow-up question on the 2 percent, if you don't mind, the prompt

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payment discount. That was factored in as among the impact -- the factors that reduced price to whatever the ASP actually was?
A. That -- that's correct.
Q. Okay. So, you just looked at the net bottom line which already bore the affect of the 2 percent discount.
A. That's correct.
Q. Okay. All right. I have one question about the effect of rebates and then that will be the end of this line of questioning. Okay. You say in your reports that the but-for rebates will be the same as the real world rebates and so, you've eliminated consideration of them, is that right?
A. Are you being purposefully that -- are we -- we're talking about in the Connecticut matter and we're talking about Medicaid rebates, right? I mean, a rebate is a very broad topic.
Q. Yes, I believe you say that in the Connecticut --
A. That -- that's correct.

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Q. Okay. You say that it's for that reason that you don't consider rebates in your calculation of damages; that they would be the same in the real world and in the but-for world.
A. I'm saying that they are related to AMP or to ASP and would be substantially the same, would -- would be of third order of importance so that, really, would net themselves out and are not sufficiently important to change the damage calculations that I have put forward.
Q. Now, if the world were as you say it should be, that in Connecticut manufacturers would be reimbursed at ASP for what they sell to Connecticut Medicaid programs?
A. I haven't said the way the world should be in anything. I'm just --
Q. But for?
A. I described --
Q. You haven't described a but-for world -- a but-for pricing mechanism?
A. I've described what the world would be like but for the -- the AWP inflation. Okay. So,

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in that context you --
Q. In that world -- in that world --
A. Right.
Q. -- Medicaid would reimburse at ASP.
A. Well, in the but-for world, they -- the but-for spread is 30 percent. So, in the but-for world there wouldn't be an inflation such that the -- that the AWP would be more than 30 percent above the ASP. That's the but-for -- that's the world without the AWP inflation. I -- the -- what the implications for calculations of damages under the Connecticut -- Connecticut Medicaid statutes or under Medicare derive from my reading of those statutes and my understanding of how they're implemented. But I don't have a -- I'm not -- the but-for world is -- let's be very clear about that -- it's just the -- there's -- there's a spread between that has been alleged to be illegal when this spread is used to move market share and take advantage of nontransparent spreads, but --
Q. If you take all my five minutes, I won't be five minutes.

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A. Well, that's --
Q. If you -- whatever the rebates are, they would reduce the spread you think is permissible in the but-for world, right?
A. Well, there are rebates already in the spread.
Q. So, the spread would be net of the rebates? In other words, rebates, the prices that would be permissible to charge in the but-for world would be a difference between ASP -- well, a difference between the amount the manufacturer received in the first instance and its -- I can't think of how to say this right -- it's the effect after the rebates that is the measure of the 30 percent, is that your testimony?
MR. NALVEN: Objection. Mr. Kaufman, could you frame the question, again, please. I don't understand the question.
Q. Do you understand the question?
A. I really don't. No, I don't.
Q. Is the 30-percent spread inclusive of the effect of rebates?

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A. The -- let's -- we -- we keep jumping, you know, back and forth between Connecticut and the MDL. The -- the 30-percent spread that we've been talking about and which I've discussed at length and its bases are relative to physician-administered drugs for which rebate payments are -- are very small. And the types of price offsets that exist, there's not payments -- there's not rebates to PBMs to move market share of physician-administered drugs.
So, this notion of what would happen with rebates or not for the 30-percent spread for physician-administered drugs, there's -- there's very little paid in the way of rebates right now.
Are you trying to say there will be some new thing with rebates?
Q. Let me go back to the question I originally asked you then. In Connecticut you say that you don't take into account the effect of rebates.
A. Of Medicaid rebates.
Q. Right. And in Connecticut the Medical

Assistance Program covers pharmacy-dispensed drugs in large measure, some physician-administered drugs, also, but mostly pharmacy-dispensed drugs, correct?
A. Correct.
Q. On which large rebates are paid.
A. Correct.
Q. Correct. What is the pricing that would avoid damages to the Connecticut Medical Assistance Program in your but-for world?
A. I haven't developed a but-for world for --
Q. Okay. What --
A. -- for self-administered drugs. I have looked at the -- what the pricing was, and I've looked at the -- the statutory reimbursements that are allowed for self-administered orals under Medicaid, but I haven't been using the 30 percent for -- for self-administered drugs.
Q. Right. You use zero spread, right?
A. I use --
Q. Zero spread.

A. I look at the -- what the --
Q. Don't you say zero spread?
MR. NALVEN: Objection.
Q. And if it's zero spread and there are rebates, the manufacturers are actually losing money, correct?
MR. NALVEN: Objection. Objection.
A. I don't understand your question.
Q. The spread that you think is permissible for reimbursement purposes in Connecticut is a zero spread between ASP and AWP, correct?
A. The spread that I -- under the Connecticut Medicaid statutes, there are -- that I read as -- that the reimbursement is to be at the lesser of what is a formulaically-based reimbursement rate related to AWP and the ASP, the estimated -- the acquisition cost, that difference is a measure of damages under the Medicaid statute for the state.
MR. KAUFMAN: Okay. I've heard you. I think I -- I think I'll stop. I have nothing further. Others in Connecticut have not yet

begun, obviously, and so, we'll have to come back. When will the witness be available?
MR. NALVEN: Well, you know, we'll compare calendars, and we'll make the witness available at a convenient time for everybody.
MR. KAUFMAN: That's appreciated. Thank you, Doctor Hartman.
THE WITNESS: Thank you.
VIDEO OPERATOR: The time is 4:59. This deposition is concluded. This is the end of Cassette 4. We are off the record.
(Whereupon the deposition recessed at 4:59 p.m.)

_____
RAYMOND S. HARTMAN, Ph.D.

Subscribed and sworn to and before me this _____ day of _____, 20____.

_____
Notary Public

Commonwealth of Massachusetts
Middlesex, ss.
I, P. Jodi Ohnemus, Notary Public in and for the Commonwealth of Massachusetts, do hereby certify that there came before me on the 1st day of March, 2006, the deponent herein, who was duly sworn by me; that the ensuing examination upon oath of the said deponent was reported stenographically by me and transcribed into typewriting under my direction and control; and that the within transcript is a true record of the questions asked and answers given at said deposition.
I FURTHER CERTIFY that I am neither attorney nor counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and, further, that I am not a relative or employee of any attorney or financially interested in the outcome of the action.
IN WITNESS WHEREOF I have hereunto set my hand and affixed my seal of office this 1st day of March, 2006, at Waltham.

_____
P. Jodi Ohnemus, RPR, RMR, CRR
Notary Public, Commonwealth of Massachusetts
My Commission Expires: 4/21/2007